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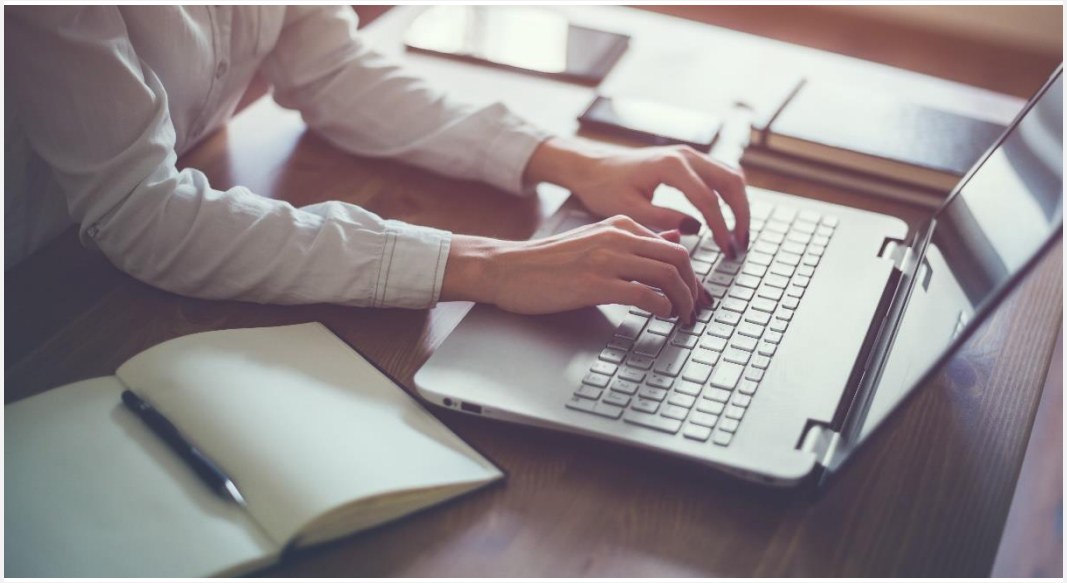
United States | Human Capital | 2 May 2025

Rewards Policy Insider
2025-09



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Supreme Court Decision Could Lead to More Litigation Against ERISA Plans

A recent unanimous Supreme Court ruling on the appropriate pleading standard for ERISA prohibited transaction claims could lead to more class action lawsuits against ERISA plan fiduciaries who hire service providers to carry out different aspects of plan administration. Although the case before the court involved a defined contribution retirement plan, the decision has potential implications for all ERISA plans – including health and welfare plans.

Background

ERISA section 406 prohibits fiduciaries from causing the plan to engage in a wide variety of transactions with a "party in interest." The term "party in interest" is very broadly defined and includes plan service providers among others.

Obviously, most ERISA plans use third-party service providers because plan sponsors do not have the capabilities to manage their benefit plans in-house. Thus, there is a statutory exception to the prohibited transaction rules in ERISA section 408(b)(2)(A) for "Contracting or making reasonable arrangements with a party in interest for office space, or legal, accounting, or other services necessary for the establishment or operation of the plan, if no more than reasonable compensation is paid therefor."

If plan participants believe that a plan's arrangement with a service provider is not reasonable, they can sue under ERISA's prohibited transaction rules. That is what happened in the case before the Supreme Court, which involved a class action challenge to a retirement plan's use of a third-party recordkeeper.

What was the Issue before the Supreme Court?

The issue before the Supreme Court was a procedural one. Essentially, the plan's fiduciaries asked for the case to be dismissed because the plaintiffs only alleged that the hiring of the recordkeeper was a prohibited transaction, without making any reference to whether the arrangement or fees were "reasonable." The trial court, and ultimately the 2nd Circuit Court of Appeals, sided with the fiduciaries, holding that in addition to asserting a prohibited transaction, plaintiffs must claim that no exception – such as the reasonableness of the arrangement of the fees – applies in order to overcome a motion to dismiss.

As a matter of statutory construction, the Supreme Court unanimously agreed to reverse the 2nd Circuit's decision. In sum, the Supreme Court ruled that in order to overcome a motion to dismiss a prohibited transaction claim, the plaintiffs only need to plead a prohibited transaction. They do not also have to allege anything to disprove the applicability of a relevant prohibited transaction exemption.

Why does the Supreme Court's ruling Matter?

As noted, the vast majority of ERISA plan fiduciaries hire one or more service providers to handle essential plan operations. Under the Supreme Court's ruling, these transactions are now more vulnerable to being challenged as prohibited transactions in class action lawsuits.

The reason is that plaintiffs now have a very low bar to clear in order to survive a motion to dismiss, and thus get to the very expensive, and time-consuming, discovery phase. In many cases, larger plans may decide it is cheaper to settle a case – even if they would ultimately prevail on the merits – than continue the process if their motion to dismiss fails. Thus, plaintiffs' attorneys have more incentive to file lawsuits if they think the odds of overcoming a motion to dismiss are in their favor.

The Supreme Court's opinion, and especially a concurring opinion filed by three justices, acknowledges this problem. However, they mostly deferred to Congress to decide if the issue should be addressed by legislation.

Department of Labor Issues 2025 Model Notice for Children's Health Insurance Program

The Department of Labor ("DOL") recently issued its annual update to the model notice for the Children's Health Insurance Program ("CHIP"). Generally, group health plans must issue this notice annually to plan participants who reside in a state that provides a premium assistance subsidy under Medicaid or CHIP. While there are no material changes to this year's update, the release of the 2025 notice serves as a reminder to employers of their CHIP notice obligations.

Background

The Children's Health Insurance Program Reauthorization Act ("CHIPRA") requires group health plans and issuers to allow employees and their dependents who are eligible for, but not enrolled in, group health plan coverage to enroll in the plan if (1) they lose their eligibility for coverage under a state Medicaid or CHIP program; or (2) they become eligible for state premium assistance under Medicaid or CHIP. CHIP provides low-cost health care coverage to children in families that earn too much to qualify for Medicaid.

In addition, CHIPRA requires employers that maintain a group health plan that covers participants in a state that provides premium assistance subsidies under a CHIP or Medicaid plan to make certain disclosures. Employers are required to notify their employees on an annual basis of the potential opportunities available in the state for premium assistance under Medicaid or CHIP. The CHIP notice requirement is dependent on where the employee resides, not on where the employer is located.

DOL has developed a model notice for employers, which it updates annually. Employers may, but are not required to, use the model notice to fulfill their CHIP notice obligations. The CHIP notice can be provided with the Summary Plan Description, enrollment packets, or open season materials.

No Material Changes to the 2025 Model Notice

For those employers who wish to use the model notice to fulfill their CHIP notice obligations, DOL recently published its annual update to the model notice, which is available here. The model notice contains basic information about premium assistance opportunities for employees and includes up-to-date information for each applicable state, such as a website and phone number.

This year, there are no major changes to the updated version of the CHIP model notice.

Executive Order Identifies Trump Administration Priorities for Lowering Prescription Drug Costs

President Trump issued a sweeping Executive Order on April 15 that outlines a number of specific actions the Administration is planning to take to lower prescription drug costs. Several proposals may have direct implications for group health plans, including one that could lead to new disclosure requirements for pharmacy benefit managers (PBMs) contracting with ERISA plan fiduciaries.

Pharmacy Benefit Managers

Pursuant to the Order, the Secretary of Labor is required to propose – within 180 days of the Executive Order's release – new regulations under ERISA section 408(b)(2) to "improve employer health plan fiduciary transparency into the direct and indirect compensation received by" PBMs.

In general, the Consolidated Appropriations Act, 2021 (CAA 2021) amended ERISA section 408(b)(2) to impose specific disclosure requirements relating to direct and indirect compensation for "consulting" and "brokerage" services provided to group health plans. Prior to CAA 2021 the Department of Labor (DOL) had issued regulations pursuant to ERISA section 408(b)(2), but those regulations applied only to retirement plans. So far DOL has not issued regulations addressing the CAA 2021 amendments to ERISA section 408(b)(2), even though those amendments have been in effect since December 27, 2021.

Previously, the Department of Labor has indicated that it interprets the scope of "consulting" and "brokerage" services broadly. Nonetheless, there is still uncertainty about how section 408(b)(2) applies, if at all, when ERISA plans are contracting with PBMs. Apparently, these new proposed regulations will address that issue – but the Executive Order did not get into specifics.

Medicare

The Executive Order outlines several initiatives relating to the Medicare and Medicaid programs. One of the most noteworthy is directing the Secretary of Health and Human Services (HHS) to propose guidance for the Medicare Prescription Drug Negotiation Program to improve the Program's transparency, "prioritize the selection of prescription drugs with high costs to the Medicare program and minimize any negative impacts of the maximum fair price on

pharmaceutical innovation within the United States." This new guidance is supposed to be issued within 60 days of the Executive Order's release, which would be sometime in mid-June.

Other Proposals

Also relevant to PBMs, the Executive Order gives HHS 90 days to make recommendations for promoting "a more competitive, efficient, transparent, and resilient pharmaceutical value chain that delivers lower drug prices for Americans." Presumably these recommendations may include regulatory initiatives as well as statutory changes.

Other supply chain related initiatives include directing the head of the Food and Drug Administration (FDA) to "take steps to streamline and improve the Importation Program under section 804 of the Federal Food, Drug, and Cosmetic Act to make it easier for States to obtain approval without sacrificing safety or quality." The FDA also must "issue a report with administrative and legislative recommendations for accelerating approvals of generics and other lower-cost alternatives to brand name prescriptions and improving the process for reclassifying prescription drugs for over-the-counter distribution."

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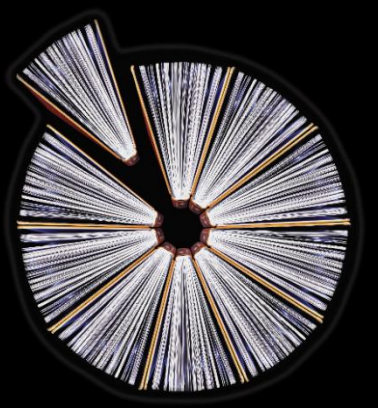

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